

## EXHIBIT "O" - Dyse Deposition

Joseph Papin

*vs.*

University of Mississippi Medical

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Deposition of:

KISHA DYSE

November 16, 2020

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Vol 01

PHIPPS REPORTING

*Raising the Bar!*

Kisha Dyse  
November 16, 2020

1                   IN THE UNITED STATES DISTRICT COURT  
2                   FOR THE SOUTHERN DISTRICT OF MISSISSIPPI  
3                   JACKSON DIVISION

4                   JOSEPH PAPIN

PLAINTIFF

5                   V.                   CIVIL ACTION NO. 3:17-CV-763-CWR-FKB  
6

7                   UNIVERSITY OF MISSISSIPPI  
8                   MEDICAL CENTER; DR.  
9                   LOUANN WOODWARD, IN HER  
10                  OFFICIAL CAPACITY; AND  
11                  DR. T. MARK EARL, IN HIS  
12                  INDIVIDUAL CAPACITY

DEFENDANTS

13                                   DEPOSITION OF KISHA DYSE

14   Taken at the instance of the Plaintiff at via Zoom  
15                   Teleconference, on Monday,  
16                   November 16, 2020,  
17                   beginning at 2:00 p.m.  
18  
19  
20  
21  
22  
23

24                                   REPORTED BY:

25                                   ROBIN G. BURWELL, CCR #1651

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2

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1 KISHA DYSE,  
2 having been first duly sworn, was examined and  
3 testified as follows:

4 EXAMINATION BY MR. MORGAN:

5 Q. If you could, please state your full  
6 name for the record?

7 A. My name is Kisha, K-I-S-H-A, Lashawna,  
8 L-A-S-H-A-W-N-A, and my last name is Dyse,  
9 D-Y-S-E.

10 Q. We met just a moment ago. But my name  
11 is Ryan Morgan, along with Jolie Pavlos on the  
12 screen there as well, we represent Joseph Papin in  
13 regards to a claim he has brought against the UMMC  
14 entities and others.

15 Is this your first deposition?

16 A. No, sir.

17 Q. How many other depositions have you  
18 given before, ballpark?

19 A. I have had one before now.

20 Q. Okay. What type of case did you have to  
21 give a deposition in?

22 A. It was a case concerning a child that  
23 was injured in a behavioral health facility.

24 Q. Ballpark, how many years ago was that?

25 A. That was 20 -- I believe it was 2010.

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1           Q.    I'll go over it since it's been a little  
2   while for you, and I'm sure probably Tommy  
3   reiterated some of these grounds rules that  
4   lawyers always like to give at the beginning of  
5   depositions.

6           A.    Yes, sir.

7           Q.    Particularly true when we're doing it  
8   this way on Zoom is to make sure that we take  
9   turns responding. Let me ask my question and I  
10   have to let you, because I'm totally guilty of it  
11   myself, of letting you finish your full answer.  
12   That way Robin, the court reporter, can type out  
13   everything and know exactly who is saying what.  
14   Okay?

15          A.    Yes, sir.

16          Q.    Yes or nos are preferable to uh-huh  
17   (affirmative response) or huh-huh (negative  
18   response.) It happens every deposition and I'll  
19   just say hey, is that a yes or a no, just to make  
20   sure the record is totally clear. Okay?

21          A.    Yes, sir.

22          Q.    If I ask a question that just does not  
23   make sense to you, please ask me to rephrase. It  
24   does not offend me at all. You're an expert in  
25   this field, I'm not. So if something just doesn't

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1 make sense, let me know. Okay?

2 A. Yes, sir, I will.

3 Q. If you need a break at any point let me  
4 know as well. I usually break every hour give or  
5 take anyways to stretch our legs. But if you need  
6 one for some reason, no problem, just let me know.

7 A. Okay. I will.

8 Q. Other than the deposition that you were  
9 describing a moment ago, have you ever testified  
10 under oath in any other capacity?

11 A. No, sir.

12 Q. I have to ask this question -- two  
13 questions to each person, so I apologize in  
14 advance.

15 A. Okay.

16 Q. Number one is have you ever been  
17 convicted of a crime before?

18 A. No, sir.

19 Q. Number two is are you on any sort of  
20 medications or drugs that could impair your  
21 ability to remember facts and things that happened  
22 years ago?

23 A. No, sir.

24 Q. Makes it easy. Good. For this  
25 deposition I don't want to know any sort of

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1 substance that you spoke about with Tommy, but I  
2 would assume you spoke with Tommy about this  
3 deposition; is that correct?

4 MR. WHITFIELD: Ryan, we lost you for  
5 about 10 seconds there.

6 MR. MORGAN: Sorry, can you hear me now?

7 (Off the record discussion)

8 Q. (By Mr. Morgan) Ms. Dyse, what I had  
9 asked you was, I don't want any substance of your  
10 conversation you had with Tommy, but I would  
11 assume you spoke with Tommy about this deposition;  
12 is that correct?

13 A. Yes, sir.

14 Q. How many times did you speak with Tommy  
15 about this deposition?

16 A. One time.

17 Q. And when was that?

18 A. I don't remember the date.

19 Q. Was it last week or before that?

20 A. It was before last week.

21 Q. Okay. Approximately how long was your  
22 conversation to prepare for the deposition?

23 A. I would say approximately one hour.

24 Q. Did you speak with anybody else besides  
25 Tommy regarding this deposition today?

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1 A. No, sir.

2 Q. Did you review any documents to prepare  
3 for this deposition?

4 A. Yes, sir.

5 Q. What documents did you review?

6 A. My charting.

7 Q. Would that be the charting for the  
8 patient with the decubitus ulcer that we're going  
9 to be discussing?

10 A. Yes, sir.

11 Q. Any other documents that you reviewed  
12 besides those?

13 A. No, sir.

14 Q. A couple of kind of background  
15 questions, Ms. Dyse. Are you married?

16 A. Yes, sir.

17 Q. How long have you been married?

18 A. I've been married for 19 years.

19 Q. Do you have any children?

20 A. Yes, I do.

21 Q. How old are they and what are their  
22 genders?

23 A. I have a 12-year old daughter and I have  
24 a 17-year old son.

25 Q. Where do you live?



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1           A.     I live in Brandon, Mississippi.

2           Q.     If you could, walk me through your  
3     education background starting with high school up  
4     through present?

5           A.     Okay. So I graduated from high school  
6     in 1994 from Wingfield High School. I then  
7     attended Hinds Community College. I obtained my  
8     associate's degree in nursing. I went back to  
9     school and obtained my bachelor's degree in  
10    nursing from Alcorn State University. And I  
11    received my -- I have two wound care  
12    certifications. My first certification I obtained  
13    in 2012, and my second wound care certification I  
14    received in 2016.

15          Q.     Do you have any master's degrees?

16          A.     No, sir.

17          Q.     For the first wound care certification  
18    in 2012, if you could, just walk me through the  
19    process to get that certification?

20          A.     That process is I went to a five-day  
21    course -- a five-day curriculum and I sat for a  
22    national exam.

23          Q.     And is there a name for that  
24    certification?

25          A.     It's just called wound care certified.

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1 Yes, sir.

2 Q. What about the 2016 one?

3 A. That one is a wound ostomy and  
4 continence nurse. That one I went to nine months  
5 of school and then I had clinicals, and after that  
6 I had to take a national exam.

7 Q. When you say nine months of school, was  
8 that a certain number of hours per week or are  
9 you --

10 A. Actually, the school is a three-month  
11 course for wound certification. It's a  
12 three-month course for ostomy and it's a  
13 three-month course for continence. But when you  
14 get the certification, they're all combined  
15 together.

16 Q. But during the regular schooling time,  
17 is it an everyday schooling type thing?

18 A. It's online so you don't go every day.  
19 You just have to have your casework finished by a  
20 certain amount of time during that week.

21 Q. I'm trying to get sort of a flavor of  
22 how rigorous this is. Is this something that  
23 you're doing 10 hours a week to study for, more or  
24 less?

25 A. I wouldn't say 10 hours a week. I would



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1 say -- I'm not sure, sir. That's been awhile ago  
2 so I'm not sure how often I studied.

3 Q. Fair to say, though, you were doing this  
4 studying in addition to your regular full time  
5 job?

6 A. Yes. Yes, sir.

7 Q. So it wasn't like you stopped working,  
8 went to the schooling for nine months and then  
9 came back?

10 A. No, sir, I worked while I was  
11 employed -- I worked while I was in school.

12 Q. Do you have any sort of continuing  
13 education that you have to comply with?

14 A. No, sir.

15 Q. So, we have your AA degree, your BA  
16 degree, the two wound care certificates. Any  
17 other designations by your name or certifications  
18 that you have received?

19 A. Well, I'm continence certified and  
20 ostomy certified.

21 Q. So those are two separate ones from the  
22 two wound care ones?

23 A. Yes, sir.

24 Q. So, in total you would have four  
25 certifications?

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1           A.     Yes, sir.

2           **Q.     What is ostomy?**

3           A.     Ostomy is people who have ileostomies,  
4     colostomies or urostomies. We take care of those.  
5     That's when a person has a diverting surgery. So,  
6     say for instance the person would have a cancer or  
7     something and they are no longer able to urinate  
8     or defecate through the anus or the urinary  
9     organs, so that person would have a stoma placed  
10    on their abdomen and that's where they would  
11    defecate or urinate.

12          **Q.     For the record, what is wound care?**

13    **When you say wound care, what do you mean by that?**

14          A.     Can you clarify that for me?

15          **Q.     Yes. You were talking about you were**  
16    **having wound care certificates and were talking**  
17    **about that you're a wound care nurse and all that.**  
18    **Just generally speaking, what does wound care**  
19    **mean?**

20          A.     Wound care means an opening in the skin,  
21    a break in the skin, and from there we would take  
22    care of that or write recommendations for it. I  
23    guess you would say any break in the skin that's  
24    not normal. Your skin has broken down in some  
25    way.

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1           Q.    I know what incontinence is, but can you  
2    just explain that for the record. I just want to  
3    make sure you and I are on the same page about  
4    things?

5           A.    Yes, sir. Incontinence is when a person  
6    can't control their bladder or bowels.

7           Q.    When you're working -- let me clarify,  
8    are you still currently employed by UMMC?

9           A.    Yes, sir.

10          Q.    What is your position?

11          A.    I'm an internal stomal therapist.

12          Q.    What does that mean?

13          A.    That's a wound care nurse, a nurse that  
14    specializes in wounds, ostomies and continence.

15          Q.    How long, ballpark, have you been in  
16    that position?

17          A.    I started at UMC in February of 2016. I  
18    stopped working there in 2018, and I just started  
19    back October 5th of this year. So October 5th,  
20    2020.

21          Q.    What was the reason for the gap in  
22    employment with UMC?

23          A.    I took another position, a consulting  
24    position at a nursing home.

25          Q.    So the -- were you in the same position

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1 the first two years from 2016 to 2018 that you are  
2 now?

3 A. Yes, sir.

4 Q. A moment ago you stated that there was  
5 no continuing education that you have to comply  
6 with for your license or anything like that. Is  
7 there any sort of like established treatises or  
8 textbook or literature that you would consider or  
9 that the wound care community considers to be the  
10 sort of gold standard?

11 A. Yes, sir. The certification that I  
12 have, the WOCN is the gold standard, and you have  
13 to recertify for that every five years. So I'm  
14 actually in the process of recertifying for that  
15 now.

16 Q. That would be the one you got in 2016?

17 A. Yes, sir.

18 Q. Generally speaking, what is the  
19 recertification process like?

20 A. You have to, of course, study. And then  
21 once you've completed your studying and you feel  
22 like you're ready to take the examination, you  
23 take it on your own terms. You have a certain  
24 amount of time to take it and you pay for your  
25 test and you sit for that national exam. It's

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1 pretty much self-study.

2 Q. Did you work in any capacity for UMC  
3 prior to February '16, like a different position  
4 or anything like that?

5 A. No, sir.

6 Q. If you could, walk me through your job  
7 history prior to February '16, sort of kind of  
8 going backwards?

9 A. Okay. Let's see. As I said I was --  
10 you want me to go backwards? So I'll say before  
11 coming to UMC I worked at Baylor All Saints in  
12 Fort Worth, Texas as a wound ostomy nurse. Before  
13 that, I worked at Select Medical Center in Texas.  
14 I was a ICU/floor nurse. Before that, I worked at  
15 Crossgates. It's now called Merit Health. I  
16 worked on the burn unit as a staff nurse. Before  
17 that, I worked at Brentwood, I think it was called  
18 Behavioral Health, as a staff nurse. And before  
19 that, I worked at Baptist Hospital as a staff  
20 nurse.

21 Q. Ballpark, when did you work for -- what  
22 was the first one you said, you said it was  
23 Baylor, Texas?

24 A. Baylor All Saints in Fort Worth, Texas.  
25 Yes, sir.



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1 Q. How long did you work there, ballpark?

2 A. I worked there from 2014 up until I  
3 started here at UMC.

4 Q. What about Select Medical?

5 A. I worked at Select Medical from 2012 to  
6 2014.

7 Q. And about Merit Health?

8 A. Merit Health I worked from 2010 to 2012.

9 Q. And Brentwood Behavioral?

10 A. Yes, sir, that was 2009 to 2010.

11 Q. And then Baptist Hospital?

12 A. That was 2008 to 2009.

13 Q. What was the nursing home that you said  
14 you took the consulting position with?

15 A. I worked at -- it's called Pine Forest  
16 Nursing and Rehab and it's in Jackson,  
17 Mississippi.

18 Q. If you could describe to me -- let me  
19 ask it a different way. Who do you report to?

20 A. I report to a nurse manager and her name  
21 is -- let me think, her name has changed. It's  
22 Mary Katy Melvin.

23 Q. What do you call yourself? Do you call  
24 yourself a wound care nurse? What terminology do  
25 you use?

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1           A.     We call ourselves wound care nurses, but  
2     according to the hospital we're internal stomal  
3     therapists.

4           Q.     How many wound care nurses are there at  
5     one time at the hospital?

6           A.     We have five now.

7           Q.     Is that typical when you were there in  
8     2016 and 2018?

9           A.     In 2016, we had between three and two  
10    depending on if somebody left or...

11          Q.     In 2016, did you also report to a nurse  
12    manager?

13          A.     I did but it was a different nurse  
14    manager. Her name in 2016 was Lee Anne Lufkin.

15          Q.     I've seen some references in the record  
16    to a Wound Care Center.

17          A.     Yes. Yes, sir.

18          Q.     What is the Wound Care Center?

19          A.     It's in the pavilion. It is an  
20    outpatient clinic.

21          Q.     Would you also work in that facility at  
22    times?

23          A.     No, sir.

24          Q.     Is it different nurses work there?

25          A.     Yes, sir, there are different nurses

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1 that work there.

2 Q. So the two to three in 2016 and around  
3 five or so now would be working in the inpatient  
4 hospital side of things?

5 A. Yes, sir, that's right.

6 Q. How do you get assigned patients?

7 A. We receive wound care consults via Epic.

8 Q. For the record, what is Epic?

9 A. Epic is our medical records computer  
10 system where we do our documentation and that type  
11 of thing.

12 Q. How does it work in real life, in  
13 practice? Is it just a rotating basis that you  
14 just rotate who receives which consult or is there  
15 a certain other way the work is divided up?

16 A. Well, different physicians or nurses or  
17 floors would put in a wound care consultation and  
18 it's a rotating of whoever is available will see  
19 that consult. We work by the one that's next in  
20 line per se.

21 Q. Okay. Is there 24-hour coverage with  
22 the wound care consults or is it certain hours  
23 typically you're working?

24 A. No, sir, it's not 24-hour coverage. Our  
25 coverage is between 8:00 and 4:30, Monday through



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1 Friday.

2 Q. A consult is entered, as an example,  
3 noon on Saturday. It's going to wait until Monday  
4 morning when people come back to work?

5 A. Yes, sir.

6 Q. For the nurse manager, do you know who  
7 the nurse manager reports to?

8 A. No, sir, I'm not sure.

9 Q. But as far as like giving feedback or  
10 discussing work issues, Mary would currently be  
11 the nurse manager you would go to?

12 A. Yes, sir.

13 Q. Is there a doctor that oversees the  
14 group or no?

15 A. No, sir.

16 Q. Any sort of semi-scheduled meetings --  
17 and by semi-scheduled, I mean do you have like a  
18 weekly department meeting or monthly meeting or  
19 anything like that?

20 A. No, sir.

21 Q. What are the most common types of wounds  
22 that you're treating?

23 A. I'm sorry, sir, I couldn't hear you.

24 Q. I'm sorry. What are the most common  
25 type of wounds that you see when you're treating

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**1 patients?**

2 A. The most common type, I would say  
3 pressure ulcers, venous stasis ulcers, sheer  
4 friction, incontinence associated dermatitis,  
5 cancer wounds, trauma wounds. Those are the most  
6 common.

**7 Q. What is a pressure ulcer?**

8 A. A pressure ulcer is a wound that  
9 develops when a sustained amount of pressure has  
10 caused an injury. The tissue has lost blood flow  
11 and so a wound will develop.

**12 Q. It could be like a bed sore, is another  
13 common name?**

14 A. Yes, sir, bed sore is another common  
15 name.

**16 Q. If you could, walk me through -- and I  
17 know every patient is different -- but your  
18 typical routine when you first see a patient and  
19 you've been given a consult?**

20 A. Okay. We will -- Epic will alert us  
21 that we have a consult. I will go to that  
22 patient's room, I will assess that patient's wound  
23 and I will write treatment recommendations based  
24 on the assessment that I just had with that  
25 patient. And I would enter those wound care

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1 recommendations into the computer.

2 Q. For your treatment recommendations, do  
3 those have to be approved by a doctor?

4 A. No, sir.

5 Q. Is anybody else involved besides you in  
6 the plan of care when you're treating the wounds?

7 A. I'm sorry, I don't understand your  
8 question.

9 Q. Do you ever typically consult with  
10 anybody else when you are sort of developing this  
11 plan of care? Like, do you talk to the attending  
12 physician or anybody else who may be relevant or  
13 is it really just on you?

14 A. I just write a wound care  
15 recommendation.

16 Q. Are there times where you're, I don't  
17 want to say stumped by one, but is it maybe a more  
18 difficult one and you feel the need to consult  
19 with the attending or someone else?

20 A. I don't usually consult with the  
21 attending over the wounds. When a wound is --  
22 when I see a wound and I write a recommendation,  
23 that's just my recommendation for the wound.

24 Q. Well, when you say a recommendation, to  
25 me that implies somebody could not follow the

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1       **recommendation?**

2           A.     That's right. Yes, sir.

3           **Q.     So who makes the decision then to follow**  
4       **that recommendation or not?**

5           A.     I'm not sure who makes that decision. I  
6       just put the recommendation as far as I see fit in  
7       the computer, and if the doctor does not want to  
8       comply with that he can delete my recommendation  
9       and put what he sees fit in the computer. He or  
10      she.

11          **Q.     So once you put it in there you really**  
12       **don't see it anymore. You're not sure what**  
13       **happens subsequently unless you keep revisiting**  
14       **the patient?**

15          A.     Yes.

16          **Q.     And after you've been assigned a**  
17       **patient, is there any sort of standard like you go**  
18       **see that patient daily or any sort of routine that**  
19       **you use to treat the patient?**

20          A.     No, sir. What happens is once I've seen  
21       the patient we are reconsulted if the wound  
22       deteriorates or if the nurse or physician needs me  
23       to look at it again.

24          **Q.     That would be coming from a consult, a**  
25       **new consult?**

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1 A. Yes, sir.

2 Q. In a perfect world you come by, do your  
3 consult, make your recommendations and then you  
4 would not have to see that patient again?

5 A. That's right, yes, sir.

6 Q. Ballpark, how often does that happen  
7 where it's just a one consult and done? Is that  
8 the majority of patients?

9 A. I don't know. I don't know. We see so  
10 many patients, I'm not sure.

11 Q. When you get a request for a second  
12 consult --

13 A. Yes, sir.

14 Q. -- is there any sort of typical  
15 timeframe which that occurs; is it a couple of  
16 days later, could it be any point later?

17 A. It could be any point later. There's no  
18 set way somebody consults. It just varies  
19 depending on the patient.

20 Q. Do you ever consult with first year  
21 residents on treatment?

22 A. No, sir.

23 Q. Do you remember Dr. Papin?

24 A. No, sir.

25 Q. So if you saw a picture of him -- you



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1 may recognize his face but you don't have an  
2 independent recollection in your head right now of  
3 who he is?

4 A. No, sir. I see so many, no, sir, I  
5 wouldn't know him.

6 Q. I know you said you've reviewed the  
7 records for this case. Do you recall this  
8 situation?

9 A. I do recall that patient, yes, sir.

10 Q. Do you recall interacting with any  
11 residents during that --

12 A. I do not recall interacting with any  
13 residents.

14 Q. Would you agree with me that your role  
15 as the wound care nurse, you had more experience  
16 diagnosing and treating wounds than a first year  
17 resident?

18 MR. WHITFIELD: Object to the form.

19 THE WITNESS: I don't know that.

20 MR. WHITFIELD: I'm sorry, you can  
21 answer.

22 THE WITNESS: No, sir, I don't know.

23 Q. (By Mr. Morgan) But fair to say that  
24 the hospital has designated you as the wound care  
25 nurse as the go-to medical treater for those

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1       wounds?

2           A.     Well, the hospital had designated me to  
3     write treatment recommendations, and that's what I  
4     do is write the recommendations.

5           Q.     You're designated -- I'm sorry. I  
6     apologize. The hospital designates you as the  
7     first line of defense so to speak to diagnose and  
8     make recommendations for those wounds?

9           A.     We don't diagnose the wounds but we do  
10    make recommendations. As a nurse I can't  
11    diagnose.

12          Q.     What do you mean by that? Can you  
13    expand on that a little bit?

14          A.     Yes, sir. As a nurse I can't  
15    specifically say -- diagnose a wound. I can put  
16    in my recommendations and I can also say based on  
17    what I see that the wound is determined -- it  
18    formed a certain way. But I can't say for certain  
19    that it is one thing or another because I can't  
20    diagnose it.

21          Q.     Is it fair to say -- correct me if I'm  
22    wrong, but is it fair to say when you're putting  
23    in your notes you can write down what you believe  
24    it is but it's not an official diagnosis?

25          A.     Yes, sir, based on the evidence of what

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1 I've seen I can say that this wound was developed  
2 through pressure.

3 Q. But A doctor could look at it and  
4 disagree with you?

5 A. I'm so sorry, I didn't hear you.

6 Q. But a doctor could come in and look at  
7 it and disagree with you?

8 A. Yes, yes, sir.

9 Q. Could any residents come in and disagree  
10 with you?

11 A. I'm not sure.

12 Q. When you're making those treatment  
13 recommendations -- I just want to clarify  
14 something, you sort of touched on this. I know  
15 you said you write them into the computer system,  
16 correct?

17 A. Yes, sir.

18 Q. But do you also talk to the doctors,  
19 typically, about those treatment options?

20 A. No, sir.

21 Q. It's just writing, that way there's a  
22 written record of it?

23 A. Yes, sir.

24 Q. Could you also start those treatments on  
25 your own?



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1           A.    No, sir. I don't start the treatments,  
2   the nurses start the treatments.

3           Q.    So if you're looking at a wound, you say  
4   hey, we need to start this process, the nurses  
5   that are there could actually do it?

6           A.    Yes, sir.

7           Q.    They don't have to wait for a doctor to  
8   say I approve it, they would just go ahead and  
9   start that treatment you recommended?

10          A.    Yes, sir.

11          Q.    Do you write orders?

12          A.    Do I write orders?

13          Q.    Yes.

14          A.    No, I only write wound care  
15   recommendations.

16          Q.    Do you know what an intern is?

17          A.    No, sir, I don't know their  
18   qualifications or anything. I hear the name, but  
19   I don't know them from a resident. No, sir.

20          Q.    Intern -- we've seen some usage of the  
21   word intern to mean resident. So a resident or an  
22   intern, do you know if a resident can write  
23   treatment options for a wound care patient?

24          A.    I don't know if they can.

25          Q.    Do you know if a resident can make an

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1 independent diagnosis of a wound care patient?

2 A. I don't know.

3 Q. Have you ever seen that happen?

4 A. I have not seen that happen.

5 Q. Have you seen where an attending  
6 physician writes a recommendation for a wound care  
7 patient?

8 A. I've not seen an attending write a  
9 recommendation. I'm not saying it didn't happen,  
10 but I have not seen that.

11 Q. That was going to be my next question.  
12 Can you recall any times where an attending  
13 physician has disagreed with your recommended  
14 treatment?

15 A. I don't know. I can't remember if one  
16 has or has not. I just don't know.

17 Q. But as we sit here right now you can't  
18 think of a specific time where a doctor -- and you  
19 found out about it -- where a doctor disagreed  
20 with you and ordered different treatment?

21 A. No, sir.

22 Q. Do any positions report to you?

23 A. I'm sorry, I didn't hear you.

24 Q. Do any positions, any employees report  
25 to you?

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1 A. No, sir.

2 Q. When -- I want to follow up on a minute  
3 ago when we were talking about how you said that  
4 once you are requested for a consult you do the  
5 consult and then you don't go back to visit the  
6 patient unless specifically requested, correct?

7 A. Yes, sir.

8 Q. So there's never a time where maybe hey,  
9 I need to just come back every day for a few days  
10 to keep checking up on this patient?

11 A. No, that would have to be put in a  
12 consult. We work on consults only.

13 Q. Okay. You testified a moment ago that  
14 you do remember this particular patient. What do  
15 you recall about this patient?

16 A. I recall that he was paralyzed, I  
17 believe, from a gunshot wound.

18 Q. Do you recall anything else about like  
19 course of treatment or anything?

20 A. I do remember his course of treatment.

21 Q. What do you remember about it?

22 A. I remember that he -- that I initially  
23 saw him and I believe he had a small wound and  
24 then he ended up developing a pressure ulcer.

25 Q. I'm going to pull up an exhibit here.

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1 MR. MORGAN: Y'all have a preference if

2 I do a share screen or drop it in the chat?

3 Doesn't matter to me, I can do both.

4 MR. WHITFIELD: Doesn't make any  
5 difference. Just let me know which one you want  
6 to do because I need to change seats and  
7 manipulate the computer.

8 MR. MORGAN: Okay. I'll do a share  
9 screen.

10 Q. (By Mr. Morgan) Ms. Dyse, do you see  
11 this record on the screen?

12 A. Yes, sir, I see it.

13 Q. We will mark this as Exhibit No. 1 for  
14 this deposition.

15 A. Yes, sir.

16 (Exhibit 1 marked for identification.)

17 Q. (By Mr. Morgan) You can see my mouse  
18 moving, can't you?

19 A. Yes, sir, I can.

20 Q. Great. This looks like, just to kind of  
21 get our bearings and all this, a consult was done  
22 on November 15th, 2016 at 0900 hours which would  
23 be 9:00 a.m.; is that correct?

24 A. Yes, sir, that's correct.

25 Q. And this looks like this was done by a

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1 different wound nurse than you, correct?

2 A. That's correct.

3 Q. Do you remember Kelly Pennock?

4 A. Yes, I do remember Kelly.

5 Q. Does she still work there or no longer?

6 A. She does work there.

7 Q. Would she be another wound nurse on  
8 basically the same equivalent level as you?

9 A. Yes, sir.

10 Q. And so looks like here it talks about  
11 how a wound care consult was ordered by Theresa  
12 Robertson. Do you see that?

13 A. Yes, sir, I do.

14 Q. Who is Dr. Robertson?

15 A. I don't know.

16 Q. This would follow what you described  
17 earlier about the only way a wound nurse gets a  
18 call is if a consult is ordered by somebody?

19 A. Yes, sir.

20 Q. And I see where it says here that this  
21 patient was high risk for pressure ulcer?

22 A. Yes, sir.

23 Q. Do you know why they would be high risk?

24 A. Yes, sir.

25 Q. Why is that?



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1           A.     Because he was paralyzed. And I believe  
2     he was incontinent as well.

3           Q.     And fair to say for somebody who is  
4     paralyzed because they're typically immobile and  
5     sitting on the same spots, that can lead to  
6     pressure ulcers?

7           A.     Yes, sir.

8           Q.     It says here for the recommendation,  
9     pressure ulcer risk/management order set. Do you  
10    see that?

11          A.     Yes, sir, I do.

12          Q.     Is that sort of a standard recommended  
13    treatment?

14          A.     Yes, sir, we have a protocol in place  
15    for pressure ulcers.

16          Q.     What does this mean to you right there,  
17    that order set?

18          A.     That means that just as she has listed  
19    there we will reposition the patient every two  
20    hours -- well, we wouldn't, but the nurses would  
21    on the floor reposition the person every two  
22    hours. He would have perineal care. We would  
23    support his bony prominence and also apply  
24    incontinence cream to protect his skin.

25          Q.     I notice some of these, like number one

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1 and five, are bolded whereas the others are not  
2 bolded. Is there any reason for that that you  
3 know of?

4 A. I'm not sure why she bolded them.

5 Q. She would have had to have physically  
6 hit Control-B to bold it?

7 A. I'm not sure, sir. Yes, she would have  
8 to, you know, put the Control-B to make it bolded,  
9 but I'm not sure why she did.

10 Q. Do you yourself ever bold certain  
11 instructions?

12 A. I don't know.

13 Q. Some people do and some people don't. I  
14 was just trying to see if that's something that  
15 you normally --

16 A. I don't know.

17 Q. Now on the bottom here it says monitor  
18 and notify MD/NP. Would that stand for a doctor  
19 or a nurse practitioner?

20 A. Yes, sir.

21 Q. And then what does the WOCN stand for?

22 A. That's our certification. It's wound  
23 ostomy and continence nurse.

24 Q. That would be the -- currently the five  
25 back -- back in 2016 the two or three nurses?

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1 A. Yes, sir.

2 Q. So if they were going to notify the  
3 wound care team, that would be, again, that  
4 consult we've been describing?

5 A. Yes, sir.

6 Q. Does UMC have an ulcer prevention  
7 program?

8 A. We have a pressure ulcer prevention  
9 protocol, yes, sir.

10 Q. What is that protocol?

11 A. It's like what Kelly had listed there.  
12 It lets the nurses know if the patient is high  
13 risk, certain things to do. That is to turn the  
14 patient, that is to protect the skin with some  
15 form of moisture barrier cream, that's to elevate  
16 the prominences, and that's to possibly elevate  
17 the feet with heel protected boots.

18 Q. Is this one through six here, is that  
19 kind of the standard pressure protocol?

20 A. It's not UMC standard protocol, but it  
21 is written in her own way. So, yes, sir, I guess  
22 you could say it's the protocol.

23 Q. Is there somewhere in writing where that  
24 standard UMC protocol would be written?

25 A. Yes, sir.



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1           **Q.     Where would that be?**

2           A.     It's under a pressure ulcer order set.  
3     You can put in pressure in Epic and it will pull  
4     down a whole list of order sets and you would  
5     click on it.

6           **Q.     What is staging a wound?**

7           A.     Staging is determining the depth of  
8     tissue damage to the wound. And that's only done  
9     with pressure ulcers.

10          **Q.     Can you stage a wound?**

11          A.     Yes, sir.

12          **Q.     Is that considered different than**  
13     **diagnosing the wound?**

14          A.     Yes, sir.

15          **Q.     I guess I want to make sure we're on the**  
16     **same page here. When I say the word diagnose and**  
17     **you're saying you can't do that, what does that**  
18     **mean to you to diagnose?**

19          A.     That means that I have assigned a  
20     medical diagnosis to a patient with -- the  
21     difference is with a wound, I can look at that  
22     wound and determine that most likely it occurred  
23     through pressure, and I do have the ability with  
24     my certification to stage a pressure ulcer.

25          **Q.     What is a decubitus ulcer?**

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1           A.     It's another way of saying a pressure  
2     ulcer. A wound that has occurred from sustained  
3     pressure between the bone and another surface.

4           Q.     So a decubitus ulcer is a little bit  
5     fancier terminology for a pressure ulcer?

6           A.     Yes, sir.

7           Q.     Are pressure ulcers preventable?

8           A.     Are they preventable?

9           Q.     Yes.

10          A.     In some cases they are, yes, sir. In  
11     some cases they are not.

12          Q.     How would it be not preventable? What  
13     are some examples?

14          A.     Some examples would be if a person is  
15     extremely compromised, say for instance that  
16     patient has no blood flow to that area or if the  
17     person is too unstable to turn, that would be an  
18     example where you couldn't avoid a pressure ulcer.

19          Q.     I'm going to share with you what we're  
20     going to mark as Exhibit 2.

21                     (Exhibit 2 marked for identification.)

22          Q.     (By Mr. Morgan) This was a consult done  
23     by you here?

24          A.     Yes, sir.

25          Q.     On November 30th, 2016, looks about 4:30

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1 in the afternoon?

2 A. Yes, sir.

3 Q. Is this -- when you were talking about  
4 records you were reviewing earlier, is this one of  
5 the records where you were tried reviewing?

6 A. Yes, sir.

7 Q. It looks like here, again, Dr. Robertson  
8 had ordered a second consult for this patient; is  
9 that accurate?

10 A. I'm not sure if that was a second  
11 consult, but it's definitely one of the consults.

12 Q. This one says here a consult by  
13 Dr. Robertson at November 30th?

14 A. Yes, sir.

15 Q. Morning. Go back to Exhibit 1, it looks  
16 like Dr. Robertson on November 14th. Do you see  
17 that?

18 A. Yes, sir.

19 Q. So it looks like to me, but correct me  
20 if I'm wrong, this is a new second consult?

21 A. Yes, sir.

22 Q. Now it has this number here starting  
23 with 941. Does that mean anything to you?

24 A. No, sir, I don't know what that means.

25 Q. I didn't know if there was like -- is

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1     that a further record that might describe this  
2     situation?

3           A.     I'm not sure.

4           Q.     When you get the requested consult, does  
5     it ever tell you why or it just says flat out  
6     consult and then you kind of have to figure it out  
7     yourself?

8           A.     Sometimes the consults will say why to  
9     see the patient.

10          Q.     Fair to say this one does not or you  
11     wouldn't be able to tell from this record whether  
12     it did?

13          A.     I just can't tell from that record.

14          Q.     So for here in this situation for some  
15     reason Dr. Robertson ordered a second consult but  
16     you can't tell from this record why that was  
17     ordered?

18          A.     That's right, yes, sir.

19          Q.     It looks like in this situation here, it  
20     looks like you -- I'm going to say the word  
21     diagnose, but I don't want you to say you don't  
22     diagnose. What would you call it here, your  
23     sentence that you says he has a partial thickness  
24     abrasion. Is that a diagnosis or you're just kind  
25     of stating a fact?

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1           A.     I'm just stating what I see.

2           **Q.     Okay. When you say a partial thickness**  
3           **abrasion, put that in layman's terms for us?**

4           A.     That means that the epidermis and the  
5           top portion of the dermis has sluffed away but it  
6           hasn't reached any deeper levels of the tissue  
7           like the subcutaneous tissue.

8           **Q.     So when you say a partial thickness**  
9           **abrasion, is that different than a pressure ulcer?**

10          A.     Yes. Yes, sir, it is.

11          **Q.     Are there similarities between the two?**

12          A.     They can look the same but the tissue  
13          would behave differently.

14          **Q.     In what way?**

15          A.     With an abrasion I could do a test  
16          called a blanching where I would press the tissue  
17          and the tissue would turn white and from white it  
18          will turn back pink. That will let me know that  
19          the blood supply is intact. So that would not be  
20          a pressure ulcer.

21          **Q.     Do you know if you did that type of**  
22          **examination here for this -- on this date?**

23          A.     Yes, I would do that. I know I did that  
24          because I would have to do that to determine that  
25          it was not pressure.



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1           Q.    You wouldn't have entered that into the  
2   note because that's just a normal practice you  
3   have to do?

4           A.    Yes, that's just normal.

5           Q.    Is it ever difficult to tell between  
6   those two things?

7           A.    I'm sorry, sir, I didn't hear it.

8           Q.    Is it ever difficult to tell between  
9   those two, an abrasion or a pressure ulcer?

10          A.    Yes, sometime it is difficult to tell.  
11   But we blanch the tissue and that helps us to  
12   determine if it's pressure related or not.

13          Q.    When you say blanch the tissue, is that  
14   the process you were describing?

15          A.    Yes, sir, that's where you press the  
16   tissue and look for blood flow to fill the wound  
17   bed.

18          Q.    Now, in this course of treatment here  
19   that you were recommending.

20          A.    Yes, sir.

21          Q.    If your test had shown that it was a  
22   pressure ulcer, would you have given a different  
23   treatment diagnosis or recommendation?

24          A.    In this case, no, that would -- I would  
25   not have done anything different.



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1           Q.    Why not? I'm just trying to understand  
2   why.

3           A.    Because he has -- he's already on a  
4   pressure redistribution mattress. All of our  
5   patients are. And the protocol for that depth of  
6   a wound is the zinc oxide, and I can tell that  
7   that's on him because I can see it in the picture.

8           Q.    So, from a pressure ulcer perspective,  
9   you were already -- and I say you, meaning the  
10   hospital and the team, were already doing what is  
11   typically used to treat that?

12          A.    Yes, sir.

13          Q.    There was nothing else, I guess, to be  
14   done at that point?

15          A.    No, sir, at that point, no.

16               MR. MORGAN: For the record, for Robin  
17   and for Tommy, what's easier for you guys, do you  
18   want me to just email you these exhibits at the  
19   end of the deposition, drop them into the chat at  
20   the end?

21               COURT REPORTER: Email them will  
22   probably be better.

23               MR. WHITFIELD: Email is fine.

24               MR. MORGAN: Okay. That works for me.  
25   I was going to go through like Bates stamps and

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1 all that, but I'll just send them to you by email.

2 We're going to mark Exhibit No. 3 here.

3 (Exhibit 3 marked for identification.)

4 Q. (By Mr. Morgan) I'm going to scroll  
5 down here because it starts here at the bottom,  
6 where you can see it looks another consult by you  
7 on December 9th. Do you see that?

8 A. Yes, sir, I see it.

9 Q. And this would have been, it looks like,  
10 again, Dr. Robertson ordered a third consult on  
11 this?

12 A. Yes, sir.

13 Q. And you came, it looks like, the next  
14 day to do the review?

15 A. Yes, sir.

16 Q. But fair to say, again, I don't see any  
17 reason on this record about why Dr. Robertson  
18 ordered the consult?

19 A. No, I can't tell from that screen.

20 Q. If a reason was listed, would it  
21 normally be on a screen like this?

22 A. The reason is usually listed under an  
23 order set page under summaries in Epic.

24 Q. Are these records we're looking at here,  
25 is this part of the Epic system? Do these look

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1 familiar to you as far as format and structure?

2 A. Well, the heading looks different. In  
3 Epic I think I will only see the pictures and the  
4 part that I had written.

5 Q. Do you remember this consult here and  
6 what you did here?

7 A. Yes, sir, I do.

8 Q. Walk through what you are seeing on this  
9 would be, I guess, the second time you had seen  
10 this patient?

11 A. Okay. The second time I see him  
12 compared to the first time, I can see that he has  
13 eschar on the wound bed.

14 Q. What is eschar?

15 A. Eschar is sometimes moist or dry  
16 necrotic tissue.

17 Q. I hate to keep asking you what does this  
18 mean, what does this mean, but I'm just doing this  
19 to make sure we're on the same page and one day  
20 this may be read to a jury. But when you say  
21 necrotic, what does that mean?

22 A. It means it's non-living tissue or dead  
23 tissue.

24 Q. Okay. I interrupted you. Keep going.  
25 I'm sorry.

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1           A.     I was done. I said it's necrotic tissue  
2     or dead tissue.

3           Q.     And what did you recommend here at this  
4     point?

5           A.     I recommended Santyl enzymatic debrider.

6           Q.     And what are those?

7           A.     Santyl is an enzyme that eats away at  
8     the necrotic tissue but leaves the intact tissue,  
9     leaves the healthy tissue alone. It will only  
10    attack the necrotic tissue.

11          Q.     At this point, it looks like you've  
12    assessed that it's not an abrasion but an  
13    unstageable pressure ulcer. Do you see that?

14          A.     Yes, sir.

15          Q.     When you say an unstageable pressure  
16    ulcer, what does that mean?

17          A.     That means that I am unable to fully see  
18    the wound bed. What I see is the eschar is  
19    covering most of the wound so I can't tell the  
20    depth of the wound.

21          Q.     I guess, how do you determine the depths  
22    of the wounds?

23          A.     You can't tell until the eschar is fully  
24    removed.

25          Q.     Is that when you can peel it back to

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1 look at it?

2 A. I can't peel it back, a physician would.  
3 But, yes, sir, when that eschar is gone you can  
4 see the true depth of the wound.

5 Q. I believe you said a physician can do  
6 that?

7 A. A physician, yes. As a nurse I can't  
8 sharp debris, which means I can't take a scalpel  
9 or anything sharp to remove that eschar. Only a  
10 physician can do that.

11 Q. For an unstageable pressure ulcer like  
12 this, the recommendations that you've made here,  
13 are those kind of a generally accepted treatment  
14 options or are these something that's kind of out  
15 of the norm?

16 A. It's generally accepted.

17 Q. Were there other options that you could  
18 have given but chose not to?

19 A. No, sir.

20 Q. From your perspective this is a pretty  
21 standard assessment in treatment option that you  
22 diagnose?

23 A. Yes, sir.

24 Q. When I say diagnose, is there a  
25 difference in your mind between a nurse diagnosis



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1     **and a medical diagnosis?**

2           A.     Yes. I just know that as a nurse we  
3     can't diagnose. We can say what we see, but we  
4     can't diagnose it or call something officially a  
5     medical diagnosis. We can just state what we see.

6           Q.     Would that be what you see here where it  
7     says assessment?

8           A.     Yes, sir.

9           Q.     It talks about for number four, change  
10    the dressing once daily. Do you see that?

11          A.     Yes, sir, I do.

12          Q.     Fair to say that wouldn't be your job to  
13    do, correct?

14          A.     No, sir, I would not do that.

15          Q.     Who typically would be the ones doing  
16    that?

17          A.     The staff nurse or the nurse that is  
18    assigned to that patient.

19          Q.     Do physicians typically change the  
20    dressings or it's more so the nurses?

21          A.     I'm not sure.

22          Q.     I see on your -- I'll call it your  
23    signature block here.

24          A.     Yes, sir.

25          Q.     What does the WCC -- is that the 2012



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1 certification we were talking about?

2 A. Yes, sir, that's wound care certified.

3 Q. And then the CWOCN one would be the 2016  
4 certifications?

5 A. Yes, sir.

6 Q. For the record, RN is registered nurse.  
7 But you're an RN?

8 A. Yes, sir.

9 Q. It looks like on this situation here for  
10 this note, it looks like your date of service on  
11 December 9th was 1340, which would be 1:40 in the  
12 afternoon, correct?

13 A. Yes, sir.

14 Q. And it looks like going down to the next  
15 page, did you come back at 1900 hours, which would  
16 be 7 p.m.?

17 A. I don't remember.

18 Q. Because it looks like two different  
19 entries to me. So my question was whether you saw  
20 this patient twice that day or is this just a  
21 followup note that you added into the Epic system?

22 A. It looks like I may have been  
23 reconsulted for that patient and I put in a note  
24 letting them know that I had already seen the  
25 patient.

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1           Q.     So do you remember if you went back and  
2     saw the patient again or are you just responding  
3     to that consult with you had already seen them  
4     today?

5           A.     I was responding by letting whoever put  
6     that consult in that he had already been seen.

7           Q.     Okay. We've been going for almost an  
8     hour. Let's just take a quick two-minute break.

9                     (Off the record.)

10          Q.     (By Mr. Morgan) I'm going to mark  
11     Exhibit No. 4.

12                     (Exhibit 4 marked for identification.)

13          Q.     (By Mr. Morgan) This is a consult  
14     encounter note for December 22nd by you. It looks  
15     like another wound care consult by Dr. Robertson.  
16     Do you see that?

17          A.     Yes, sir, I do.

18          Q.     If you could, walk me through -- walk me  
19     through this one when you came back. I guess this  
20     would have been your third visit to this patient?

21          A.     Yes, sir. You said walk you through it?

22          Q.     Yes. What you saw and what you were  
23     doing?

24          A.     I saw he still has his black eschar.  
25     The wound has increased in size. 90 percent

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1     eschar, 10 percent pink viable tissue. He has  
2     serosanguinous drainage. A small amount. It's  
3     irregular shaped and the wound edges are open and  
4     macerated. I recommend to continue the use of the  
5     Santyl.

6           Q.     When you say the wound edges are  
7     irregular and there's macerated edges, what does  
8     that mean to you?

9           A.     Irregular means the shape isn't -- it  
10    isn't a circle or a complete circle or a square.  
11    It kind of has an irregular outline to the shape  
12    of the wound. And then macerated means that it's  
13    moist. It's just another name for something  
14    that's moist.

15          Q.     And your recommendation to the continued  
16    use of Santyl --

17          A.     Yes, sir.

18          Q.     -- was that, again -- my question from  
19    before, is that the sort of standard response to  
20    this situation or are there other courses of  
21    treatment you could have chosen?

22          A.     At that moment when I looked at it,  
23    Santyl was the best option.

24          Q.     At this point it was still an  
25    unstageable one, because you testified you could

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1       not use a scalpel to peel back the eschar?

2           A.     Yes, sir, that's correct.

3           Q.     Could you have asked somebody to do it?

4           A.     Could I ask someone to debride it?

5           Q.     Yes, so that you could stage it?

6           A.     Well, when I looked at it I saw what I  
7       saw and I felt like Santyl was appropriate.

8           Q.     But if for some reason you saw the scab  
9       or the eschar, could you have requested somebody  
10      to peel that back to get a better look at it?

11          A.     Well, the Santyl is working. From what  
12      I see, the Santyl is working appropriately at that  
13      moment that I looked at it. It looks like it was  
14      working appropriately.

15          Q.     So this exam by you would have been done  
16      at 10:59 a.m.?

17          A.     Yes, sir.

18          Q.     So when it says date of service, that's  
19      literally the time when you were there with the  
20      patient doing your treatment?

21          A.     Yes, sir.

22          Q.     The pressure ulcer is now  
23      four-and-a-half centimeters by five.

24          A.     Yes, sir.

25          Q.     How do you measure that?

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1           A.     You measure length. Which was  
2     4.5-centimeters and length would be basically the  
3     length of -- the shape of the spine. So from head  
4     to toe would be 4.5. And 5.0 would be width or  
5     across the wound.

6           Q.     During this exam would you have done  
7     that same test you had described earlier with the  
8     pressure on it?

9           A.     No, sir, you can't do that with eschar.

10          Q.     So you did that with -- the first time  
11     you saw this patient, correct?

12          A.     Yes, sir, because the wound bed wasn't  
13     covered by eschar.

14          Q.     Would you have done it at the second  
15     examination? If you need to go back to that note  
16     I can, on Exhibit 3?

17          A.     No, because the eschar is what's used to  
18     stage it at that point.

19          Q.     What do you mean by that?

20          A.     The wound is beyond the depth of the  
21     dermis so the blanching wouldn't be appropriate.  
22     I could see the eschar on the wound bed which lets  
23     me know that the wound is unstageable.

24          Q.     From the second time to the third time,  
25     obviously, this ulcer is getting bigger, fair to



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1 say?

2 A. Yes, it is bigger.

3 Q. And the eschar is getting to be larger?

4 A. Yes, sir.

5 Q. Is there a point in time where when  
6 you're looking at a patient like this where --  
7 maybe emergency is the right word. Right, when  
8 you're looking at something and you say my  
9 goodness, this is really, really bad, this is an  
10 emergency, we need a doctor in here right away.  
11 Has that ever happened?

12 A. It has happened before, yes, sir.

13 Q. A situation like this here, what would  
14 have needed to have occurred for you to kind of  
15 take that course of action?

16 A. What would make me take that action  
17 would be if the eschar was what we call unstable.  
18 That means that the eschar is lifted up and if the  
19 wound was showing signs of infection. And that  
20 would require that a physician would immediately  
21 get involved.

22 Q. I was going to ask because I -- you were  
23 saying you couldn't do that yourself?

24 A. No, I cannot remove the eschar, no, sir.

25 Q. So then what would cause you to request



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1 a physician to do that?

2 A. If the wound was showing signs of  
3 infection or if the eschar was unstable then I  
4 would request that a physician would see it.

5 Q. So in this situation here on Exhibit 4,  
6 this situation did not meet those two options?

7 A. From my standpoint, no, sir.

8 Q. Have you ever heard the term grossly  
9 necrotic?

10 A. Grossly necrotic?

11 Q. Yes.

12 A. No, sir.

13 Q. We talked about what necrotic was  
14 earlier. Would you consider this at this point  
15 here to be a necrotic wound?

16 A. It is a necrotic wound, yes, sir.

17 Q. You checked for whether the wound  
18 smells? I've seen some documents referring to it  
19 as foul smelling.

20 A. Yes.

21 Q. Is it something as kind of a routine  
22 check?

23 A. Yes, sir.

24 Q. So you would have checked it in this  
25 situation for Exhibit 4, correct?

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1 A. Yes, I would have.

2 Q. And if it was foul smelling I would  
3 imagine you would notate that in the record?

4 A. Yes.

5 Q. But you did not here?

6 A. No, sir, I did not.

7 Q. Walk me through how it kind of works in  
8 real life. I know you said earlier that -- I  
9 don't want to put words in your mouth so correct  
10 me if I'm wrong here. That typically you would  
11 make your assessment, but you're not like  
12 assessing it with an attending physician there.  
13 You enter your treatment in and the attending  
14 physician see it there later. But are there other  
15 people in the room with you, typically, who are  
16 there watching your treatment that you're talking  
17 with and giving your thoughts to?

18 A. No, sir.

19 Q. It's usually just you?

20 A. Yes, sir, or maybe a nurse helping me  
21 position the patient. But I'm the only one making  
22 the decision.

23 Q. Are there ever times where you leave  
24 after doing a treatment like this with a patient  
25 where you say you know what, I think I need to

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1 talk to the physician or somebody else about this  
2 particular case. Maybe not quite as bad as the  
3 emergency one we were talking about a moment ago,  
4 but something where you felt you needed to do more  
5 that just enter the note in the system?

6 A. Can you repeat your question?

7 Q. Yes, because it was not the greatest  
8 question in the world. A moment ago we talked  
9 about how there can be situations where you look  
10 at it and it's a true emergency. Do you recall  
11 that?

12 A. Yes, sir.

13 Q. Are there ever times where maybe it's  
14 not an emergency but you still feel the need to go  
15 seek out the physician or somebody else to discuss  
16 that patient?

17 A. Yes, sir, there are times when I've had  
18 to do that.

19 Q. What kind of situations would cause you  
20 to do that?

21 A. If the wound is infected or if I'm  
22 seeing the eschar is unstable.

23 Q. The two we just discussed?

24 A. Yes, sir.

25 Q. But to confirm, on this here for Exhibit

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1 4, you did not see those two things?

2 A. I did not, no, sir.

3 (Exhibit 5 marked for identification.)

4 Q. (By Mr. Morgan) We're going to mark  
5 Exhibit 5. It should be up on the screen now.

6 A. Yes, sir.

7 Q. So this is another note but this is the  
8 one that is entered by Dr. Papin. Do you see this  
9 up here?

10 A. Yes, sir, I do see it.

11 Q. December 22nd. 7:51. Which if you go  
12 back to the previous one that you saw, you saw the  
13 patient at December 22nd at just about 11:00 a.m.  
14 Do you see that?

15 A. Yes, sir.

16 Q. So this Exhibit 5, Dr. Papin's note is  
17 approximately just over three hours prior to when  
18 you saw him, the patient.

19 A. Yes, sir.

20 Q. It describes how he saw Mr. Newesome  
21 today with -- I'm sorry, this is the attending  
22 physician, I believe. Do you know who Dr. Batson  
23 is?

24 A. No, sir.

25 Q. But she notates here that she saw

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1 Mr. Newsome with the resident today and she  
2 agrees with the note. Do you see that?

3 A. Yes, sir, I do.

4 Q. Were you aware that residents and  
5 attending physicians would round to the patients?

6 A. I don't know what they do, sir.

7 Q. Now it would be fair to say that if  
8 Dr. Papin saw this patient about three hours prior  
9 to when you saw the patient, that your assessment  
10 here in Exhibit 4 would be fairly similar to what  
11 Dr. Papin would have seen three hours prior?

12 A. I don't know what he would have seen.

13 Q. Any reason to believe that what he would  
14 have seen would have been way worse than what you  
15 saw?

16 A. I don't know.

17 Q. Can you think of any reason why that  
18 would happen?

19 A. No, sir, I don't have a reason why.

20 Q. Or maybe the opposite way. Is there any  
21 reason why you seeing it three hours later it  
22 would be way worse than when Dr. Papin saw it?

23 A. No, I don't know.

24 Q. Fair to say that they should be similar?

25 A. I don't know.



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1           Q.    You don't think that the wound and what  
2    you are looking at would be similar from three  
3    hours before you saw it?

4           A.    I don't know what he would have seen. I  
5    just know what I saw, and what I saw is what I  
6    documented there.

7           Q.    Let me go back to -- I'm sorry, you did  
8    answer but let me just confirm. I know I asked  
9    you this and I apologize. Here in Exhibit 4, the  
10   November{sic} 22nd date you saw the patient. If  
11   it was infected, you would have notated that on  
12   the record?

13               MR. WHITFIELD: I'm going to object to  
14   the form. I think you just read the date wrong,  
15   that's my only objection. You said November and I  
16   think it's December.

17           Q.    (By Mr. Morgan) Sorry. December 22nd  
18   note. If the wound had been infected, you would  
19   have notated that?

20           A.    Yes, sir, if that sacrum wound is  
21   infected, I would have notated that.

22               (Exhibit 6 marked for identification.)

23           Q.    (By Mr. Morgan) We're showing here what  
24   will be marked as Exhibit 6. This is a note that  
25   is entered here December 23rd. So that would have



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1     been the following day after the record we were  
2     just looking at, correct?

3             A.     Yes, sir.

4             Q.     It states that patient had been having  
5     fevers.   Examine, reveals sacral decubitus ulcer  
6     wound.   It says this patient needs to go to the  
7     OR -- which I imagine stands for operating room?

8             A.     Yes, sir.

9             Q.     -- today for exploration and  
10    debridement.   What is debridement?

11            A.     That's removal of dead tissue.

12            Q.     This was done by a doctor, this looks  
13    like.   This was a doctor's diagnosis; is that  
14    correct?

15            A.     Yes, sir.

16            Q.     Do you know who Dr. Carroll is?

17            A.     No, sir.

18            Q.     It reveals a sacral decubitus ulcer.  
19    That's similar to what you had diagnosed, correct?

20            A.     I didn't diagnose it but...

21            Q.     You assessed it?

22            A.     Yes, sir.

23            Q.     It's the same thing you had assessed?

24            A.     Yes, sir.

25            Q.     But a day later this doctor felt it was

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1      necessary to operate, essentially?

2            A.    Yes, sir.

3            Q.    Is that normal in this area of medicine  
4      for this type of situation to occur?

5            A.    I'm not sure.

6            Q.    Have you ever heard of it happening in a  
7      different setting, besides this patient I mean?

8            A.    I don't recall.

9                    (Exhibit 7 marked for identification.)

10           Q.    (By Mr. Morgan) We'll mark this last  
11      one here as Exhibit 7. I'm going to scroll down  
12      here. You can see here -- let me go back up --  
13      that this was a note that was originally entered  
14      on December 23rd, 2016?

15           A.    Yes, sir.

16           Q.    The date of service there. So that  
17      would have been a little bit later in the day that  
18      we were just looking at and one day after your  
19      last visit to that patient?

20           A.    Yes, sir.

21           Q.    If you scroll down to the procedure  
22      details.

23           A.    Yes, sir.

24           Q.    It talks about how the ulcer is now 10  
25      by 10 centimeters?

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1 A. Yes, sir.

2 Q. Do you see that?

3 A. Yes, sir.

4 Q. If you go back to Exhibit 4, which was  
5 the day before, you had it at four-and-a-half by  
6 five centimeters?

7 A. Yes, sir.

8 Q. Is that normal for an ulcer to grow that  
9 rapidly in one day?

10 A. I've never seen it grow that rapidly in  
11 one day.

12 Q. Is it possible that it was larger than  
13 what you had notated in this record?

14 A. I can't see the wound bed, I can only  
15 see the small amount of eschar, the 4.5 by 5.0  
16 amount of eschar, that's all I can see. Because  
17 as I stated before, I can't see the wound bed  
18 behind the eschar.

19 Q. So you believe that this 10 by 10 would  
20 have been viewed from underneath the eschar or do  
21 you know?

22 A. It would have to be underneath it.  
23 Because from what we see from my picture it's 4.5  
24 by 5.0.

25 Q. And you could see in this note it

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1 describes that the ulcer was foul smelling?

2 A. Yes, sir.

3 Q. But like we discussed, had you smelled a  
4 foul smell the day before you would have notated  
5 that on the record?

6 A. Yes, sir.

7 Q. And then it says here there's evidence  
8 of grossly necrotic tissue present. Do you see  
9 that?

10 A. Yes, sir.

11 Q. That's why I asked you a few minutes ago  
12 if you ever heard the term grossly necrotic. Does  
13 this help put in context what I was asking before  
14 about that term?

15 A. Yes, sir, eschar is necrotic tissue.

16 Q. I guess more my question is there's a  
17 difference between necrotic and then something  
18 that's grossly necrotic or extremely necrotic. Is  
19 that an accepted terminology that you use in your  
20 field when describing?

21 A. I just use necrotic.

22 Q. So even if it's the tiniest little bit  
23 versus a very, very large amount, you would just  
24 write necrotic?

25 A. Yes, sir.

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1           Q.    Have you ever seen pressure wounds like  
2    this worsen so quickly?

3           A.    You said have I?

4           Q.    Have you, yes.

5           A.    No, sir.

6           Q.    Have you ever heard of them in any of  
7    the literature or other case studies?

8           A.    I have not read the literature on them.

9           Q.    Based on your opinion, what do you think  
10   happened here with this patient as it kept  
11   progressively getting worse?

12               MR. WHITFIELD: Object to the form.

13           Q.    (By Mr. Morgan) You can answer,  
14   Ms. Dyse.

15           A.    I'm not sure. I can only go by what I  
16   saw, and what I saw was what's in the picture.

17           Q.    So the day before on the 22nd when you  
18   saw it you didn't notate any foul smell, and you  
19   still believe that the proper course of treatment  
20   was what you prescribed on that day?

21           A.    Yes, sir.

22           Q.    Following this patient -- did anybody  
23   ever come to you and discuss the care for this  
24   patient?

25           A.    No, sir.



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1 Q. This is kind of the first time you've  
2 been talking about it since then?

3 A. Yes, sir.

4 Q. Did anybody ever come to you after the  
5 fact and talk to you about Dr. Papin and his role  
6 with this patient?

7 A. No, sir.

8 Q. Fair to say no one has mentioned  
9 Dr. Papin to you in several years?

10 A. No, sir, no one has ever mentioned  
11 Dr. Papin to me except in this encounter.

12 Q. When was the first time you found out  
13 about this deposition?

14 A. When I came to Mr. Whitfield's office.

15 Q. You were just told by somebody hey, you  
16 need to go to Mr. Whitfield's office?

17 A. I spoke with him on the telephone.

18 MR. WHITFIELD: I'm going to object to  
19 what we talked about, but go ahead.

20 Q. (By Mr. Morgan) Understood. And I  
21 don't want to get into attorney-client  
22 communications.

23 Prior to your discussion with  
24 Mr. Whitfield had anybody at the hospital or  
25 anywhere else, besides Mr. Whitfield, talked to



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1     you about Dr. Papin?

2             A.     No, sir.

3             Q.     Now during this timeframe -- because you  
4     know these records span sort of mid-ish November  
5     all the way through December, so roughly a five to  
6     six-week period. You saw this patient several  
7     times, correct?

8             A.     I'm sorry. Can you say that again? I  
9     just didn't hear the last part.

10            Q.     That's okay. I asked that during this  
11    timeframe you saw this patient several times,  
12    correct?

13            A.     Yes, sir, I believe three times.

14            Q.     And attending physicians would have also  
15    seen this patient, correct?

16            A.     I'm not sure.

17            Q.     Do you know if residents would have seen  
18    this patient?

19            A.     I'm not sure.

20            Q.     Would you agree with me that nurses saw  
21    this patient, besides you?

22            A.     Yes, sir.

23            Q.     Floor nurses and other assigned nurses  
24    to the patient, correct?

25            A.     Yes, sir.

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1           Q.    And fair to say you would expect that  
2   they followed your instructions to change the  
3   bandages and the dressings every day?

4           A.    I just wrote the recommendations. I'm  
5   not sure if they follow it or not.

6           Q.    Is it your experience at UMC that nurses  
7   typically do not follow your recommendations?

8           A.    No, I just write the recommendations and  
9   I'm not sure if they follow or not. I'm not sure  
10   if they follow.

11          Q.    Have you ever heard about somebody not  
12   following your recommendations?

13          A.    No, sir.

14          Q.    We talked earlier about how a doctor can  
15   override your instructions?

16          A.    Yes, sir.

17          Q.    If that was done, would you expect that  
18   to be notated in the patient's file?

19          A.    I'm not sure, sir.

20          Q.    Would you expect there would be a doctor  
21   note that followed yours saying something  
22   different, that as a doctor I'm diagnosing this as  
23   this with this treatment?

24          A.    No, sir, because the only time I would  
25   have any other engagement with the patient would

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1 be with another consult. So I wouldn't know one  
2 way or another if the doctor had done something  
3 different.

4 Q. But if you -- if you came back for a  
5 second consult?

6 A. Yes, sir.

7 Q. And in between your first and second  
8 consult a doctor had made other orders, would it  
9 be fair to say that you would expect to see those  
10 orders within the patient's file?

11 A. Yes, sir.

12 Q. That's what I'm getting at. If there  
13 was a time some doctor disagreed with your  
14 assessment, it's not just a verbal disagreement,  
15 it would be notated in the records?

16 A. Yes, sir.

17 Q. Do you think anybody is to blame for  
18 this patient's care for this ulcer occurring?

19 A. I don't know, sir.

20 Q. You don't know, no or you just have no  
21 idea?

22 A. I don't know. I just don't know one way  
23 or another.

24 Q. Do you know what an ICARE report is?

25 A. Yes, sir.

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1 Q. Do you know if an ICARE report was done  
2 on this patient?

3 A. I don't know, sir.

4 Q. Have you ever been involved in other  
5 ICARE reports?

6 A. No, sir.

7 Q. What is an ICARE report for the record?

8 A. To my knowledge it's a computer-based  
9 form. We go in and voice our opinions about  
10 something that we felt like was done wrong.

11 Q. Is that something that you prospectively  
12 do yourself or are you requested to complete it or  
13 both?

14 A. I'm encouraged to do it if I need to do  
15 one. I've never done an ICARE report.

16 Q. If a patient or a family member of a  
17 patient or whatever complains about the care that  
18 is given to a patient, typically the hospital is  
19 the one to investigate that, correct?

20 A. I'm not sure, sir.

21 Q. Have you ever been involved in any sort  
22 of investigation as to patient care for a patient  
23 that you were seeing?

24 A. No, sir.

25 Q. Have you ever heard of it happening?

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1 A. No, sir.

2 Q. You don't have any personal experience  
3 or knowledge from any other wound care nurse of  
4 that type of situation happening?

5 A. No, sir.

6 Q. I believe I asked this earlier but I  
7 just want to confirm. After this timeframe that  
8 we're talking about, did anybody ever come to you  
9 and say that they believed you didn't give  
10 sufficient care to this patient?

11 A. No, sir.

12 Q. From your perspective, you did  
13 everything right with this patient?

14 A. Yes, sir.

15 Q. Let's take another couple minute break.  
16 (Off the record.)

17 Q. (By Mr. Morgan) Ms. Dyse, we kind of  
18 talked throughout this deposition about how a  
19 doctor can override your assessment and your  
20 course of treatment plans, correct?

21 A. Yes, sir.

22 Q. If that's the case, then all these  
23 consults are being ordered by doctors. I guess,  
24 why are they reaching out to you for the wound  
25 care team to make the assessments?



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1           A.     You say why are they?

2           **Q.     Why are they?**

3           A.     I'm not sure. I guess it's just -- the  
4 reasons vary. It kind of helps the physicians to  
5 streamline the service. By having us available we  
6 could see the wounds and at least make  
7 recommendations.

8           **Q.     Be fair to say that this is your world,**  
9 **you see this every day, you've got multiple**  
10 **certifications that you've achieved over the**  
11 **years, you're a pretty authoritative figure when**  
12 **it comes to wounds. Is that a fair**  
13 **characteristic?**

14                   MR. WHITFIELD: Object to the form.

15           **Q.     (By Mr. Morgan) You can still answer.**

16           A.     Well, I just do my job every day. I  
17 wouldn't say I'm an authority. Based on my  
18 education, I just assess a wound and I make  
19 recommendations based on what I see.

20           **Q.     Have you ever heard the term wound care**  
21 **specialist?**

22           A.     Yes.

23           **Q.     Is that another name that they call your**  
24 **position?**

25           A.     Yes, sir.



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1 Q. So you're a specialist in wound care?

2 A. Yes, sir.

3 Q. Have you seen some other cases like this  
4 where -- notwithstanding the treatment that occur,  
5 a pressure ulcer just ultimately somehow develops?

6 A. Yes, sir.

7 Q. It's something that happens in medicine;  
8 is that fair to say?

9 A. Yes, sir, it does happen.

10 Q. Fair to say you can do all sorts of  
11 treatments and sometimes pressure ulcers are just  
12 going to happen?

13 A. Yes, sir, they happen. Yes, sir.

14 Q. Does anyone at the hospital at UMC  
15 review your work? Do you get like a yearly review  
16 or anything like that?

17 A. Yes, sir, we get an annual review.  
18 Evaluation.

19 Q. Is that your nurse manager who does  
20 that?

21 A. Yes, sir.

22 Q. As part of that review, do they review  
23 your -- I don't want to say medical knowledge,  
24 that's not the right term I'm looking for. But  
25 whether you're doing a good job assessing and

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1     **treating patients?**

2           A.     They just assess my behavior and how  
3     I've carried myself at the job. They don't review  
4     patients or anything in the review.

5           Q.     If a wound care specialist was just, I  
6     hate to say this, but just not very good and  
7     screwing up, who would be the one who would say  
8     look, this person is screwing up and just not a  
9     good nurse?

10          A.     I don't know who -- my manager would  
11     contact me, but I don't know who would contact  
12     her.

13          Q.     Do you know if a doctor would?

14          A.     I don't know.

15          Q.     Ever heard of that occurring?

16          A.     I've never heard of it occurring. It  
17     hasn't happened to me.

18          Q.     Fair to say your reviews have been  
19     positive?

20          A.     Yes, sir.

21                 MR. MORGAN: I don't have any more  
22     questions.

23     EXAMINATION BY MR. WHITFIELD:

24          Q.     I just have a couple of clear-up, just a  
25     few small things.

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1           A.     Yes, sir.

2           Q.     I don't remember what exhibit it was,  
3     but when he put up the note of Dr. Papin on  
4     December 22nd, 2016; do you remember that exhibit?

5           MR. MORGAN: I can pull it up. It was  
6     Exhibit 5.

7           Q.     (By Mr. Whitfield) That was Dr. Papin's  
8     note for his view of the patient at seven  
9     something in the morning; is that correct?

10          A.     Yes, sir.

11          Q.     Is there any reason the record to show  
12     where he even examined the wound or made notes of  
13     what it looked like on that date?

14          A.     Not from what I see in front of me, no,  
15     sir.

16          MR. WHITFIELD: Can you scroll through  
17     the --

18          MR. MORGAN: Is this a good speed?

19          THE WITNESS: Yes, sir, that's a good  
20     speed.

21          MR. MORGAN: This looks like a physical  
22     therapist note at this point.

23          Q.     (By Mr. Whitfield) You've had an  
24     opportunity to look at the note there. Was there  
25     anything in the note there that showing where he

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1 personally examined the wound or his notes of his  
2 examination of the wounds?

3 A. No, I don't see that there.

4 Q. So there's nothing in the record that  
5 showed that he even looked at the wound?

6 A. Not that I see, no, sir.

7 Q. And when you're looking at that wound,  
8 that's a late stage decubitus ulcer, right, not an  
9 early stage?

10 A. That's a late stage, yes, sir.

11 Q. And if he would have examined it, you  
12 would have expected to see something in the  
13 record?

14 A. Yes, sir.

15 MR. WHITFIELD: Nothing further.

16 EXAMINATION BY MR. MORGAN:

17 Q. I'm going to go back to Exhibit 5 here,  
18 Ms. Dyse. You see where it says Dr. Batson also  
19 saw the patient with the resident today. Do you  
20 see that?

21 A. Yes, sir, I do.

22 Q. Do you see anywhere in this note where  
23 Dr. Batson examined the patient?

24 A. No, sir, not from what I see there.

25 MR. MORGAN: No more questions.

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1 (Time Noted: 3:45 p.m.)

2 SIGNATURE/NOT WAIVED

3

4 ORIGINAL: MR. MORGAN, ESQ.

5 COPY: MR. WHITFIELD, ESQ.

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1 CERTIFICATE OF DEPONENT

2 DEPONENT: KISHA DYSE  
DATE: November 16, 2020  
3 CASE STYLE: Papin vs. UMMC  
ORIGINAL TO: Mr. Morgan, ESQ.

4 I, the above-named deponent in the  
deposition taken in the herein styled and numbered  
5 cause, certify that I have examined the deposition  
taken on the date above as to the correctness  
6 thereof, and that after reading said pages, I find  
them to contain a full and true transcript of the  
7 testimony as given by me.

8 Subject to those corrections listed below,  
if any, I find the transcript to be the correct  
testimony I gave at the aforesated time and place.

9 Page Line Comments

10	_____	_____	_____
	_____	_____	_____
11	_____	_____	_____
	_____	_____	_____
12	_____	_____	_____
	_____	_____	_____
13	_____	_____	_____
	_____	_____	_____
14	_____	_____	_____
	_____	_____	_____
15	_____	_____	_____
	_____	_____	_____
16	_____	_____	_____

17 This the \_\_\_\_ day of \_\_\_\_\_, 2020.

18 \_\_\_\_\_  
KISHA DYSE

19 State of Mississippi  
20 County of \_\_\_\_\_

21 Subscribed and sworn to before me, this the  
\_\_\_\_ day of \_\_\_\_\_, 2020.

22 My Commission Expires:

23 \_\_\_\_\_

24 Notary Public

25



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1 CERTIFICATE OF COURT REPORTER

2 I, Robin G. Burwell, Court Reporter and  
3 Notary Public, in and for the State of Mississippi,  
4 hereby certify that the foregoing contains a true  
5 and correct transcript of the testimony of KISHA  
6 DYSE, as taken by me in the aforementioned matter at  
7 the time and place heretofore stated, as taken by  
8 stenotype and later reduced to typewritten form  
9 under my supervision by means of computer-aided  
10 transcription.

11 I further certify that under the authority  
12 vested in me by the State of Mississippi that the  
13 witness was placed under oath by me to truthfully  
14 answer all questions in the matter.

15 I further certify that, to the best of my  
16 knowledge, I am not in the employ of or related to  
17 any party in this matter and have no interest,  
18 monetary or otherwise, in the final outcome of this  
19 matter.

20 Witness my signature and seal this the  
21 30th day of November, 2020.

22 *Robin G. Burwell*

23 ROBIN G. BURWELL, #1651  
24 CRR, RPR, CCR

25 My Commission Expires:  
April 6, 2021

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